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Case report

A crisis worker's observations on the psychosocial support for victims and families following child sexual abuse; a case study

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ABSTRACT

The Lancashire Sexual Assault Forensic Examination (SAFE) centre in Preston saw 204 children aged 16 and under for examination following allegation of sexual assault in 2013. The psychological impact on the child is well known but not always addressed correctly or appropriately; the impact and resulting difficulties faced by the parent/carer of the child can also easily go un-noticed.

Mrs A attended the centre with her 2 year old daughter in 2013, where I was the crisis worker in the case. She was contacted five months later and the support they received after attending the centre discussed. Her experiences, along with my own anecdotal experiences are discussed. Independent Sexual Assault Advisors (ISVAs) offer support following attendance at the centre, and various charitable organisations offer counselling, emotional and practical support. Health visitors, paediatricians, school nurses and social workers also play a role in looking after children and families following allegations of assault. However, the organisations and agencies involved in psychological aftercare for victims and parents are hindered by strict referral criteria and lack of funding or appropriate specialist expertise. The psychological, educational and behavioural support for parents and children, and specifically pre-trial counselling for children need significant improvement if we are to offer the best support for victims.

1. Introduction

The Lancashire SAFE centre, a sexual assault referral centre (SARC) covering the whole of Lancashire and Cumbria, saw 204 cases of alleged sexual assault against children aged 16 and under in the year 2013 compared to 158 in 2012, an increase of 29%.[1] It provides a 24/7 service all year round, and since opening in October 2002 to the end of 2013, a total of 2358 complainants aged 16 and under have been through the centre.[1] 35.1% of all cases were aged 16 and under, with a significant proportion aged between 14 and 19.[1] A dedicated Children's Examination Suite was opened in October of 2012, and it is possible that the availability of the suite and of paediatric examiners resulted in an increase in referrals for examination (amongst other factors). The increase in cases nationally, not just in Lancashire and Cumbria, has created an increased demand for specialist services. However it may also be that cases are being managed more comprehensively and the psychological needs of victims are now being addressed more thoroughly, leading to an increase in referrals to other agencies.

Complainants are seen and examined at the centre, and appropriate follow up arranged; be it with Genito-Urinary Medicine, Paediatrician referral, Social Services or via General Practitioner correspondence. Two dedicated Independent Sexual Violence Advocates (ISVA) follow up those seen at the centre, should they wish to access their support. One of these ISVAs is specifically for adults; the other is a Children's and Young Person's Advocate (CYPA), seeing children and their parents/carers, offering emotional and practical support as well as advising parents/carers of the process after attending the centre and of the criminal proceedings. They do not offer counselling but signpost or refer on to other services if psychological therapy or counselling is requested. The follow up for psychological support however, is less clear cut and the case below highlights how difficult organising psychological support can be.

2. Case study

2.1. Background

Child A, the daughter of Mr and Mrs A was brought to the centre in August 2013 following a disclosure which resulted in a police

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referral. Mr and Mrs A were married and had two children between them; Child A- a female and Child B, a male. Child A, aged two, was accompanied by Mrs A and the police for examination, having disclosed that she had been touched on her bottom by her Father, Mr A. Although examination was unremarkable and no signs of injury found, it was impossible to say if anything had happened. Mr A denied the allegation, stating he had simply been cleaning Child A whilst changing her nappy and that this had been misinterpreted by Child A. The police soon closed the case due to a lack of evidence and social services continued to manage the case, with Mrs A being the sole carer. Mr A was estranged from Mrs A but subsequently allowed supervised contact with Child A.

Telephone contact was made with Mrs A five months later and her experiences after attending the centre were discussed at length. She said she could not fault our work at the centre but the aftercare she has received has been extremely poor and described the experience as "hell". Social services received an appropriate referral from the police for Child A and they began investigating the case. Mrs A stated social services had "caused nothing but distress" during their initial investigation. Instead of supporting her through the ordeal, she claims they would turn up unannounced and ask to enter the house. Mrs A felt the social services investigation was not explained to her and she often felt interrogated herself. They would not discuss the case investigation with her, stating there were data protection issues with obtaining the social services report; she describes the process as being far from transparent, "cloaked" and secretive, with little information available for her. She told me she sometimes worries that they could take her children away from her and wonders what would happen should one of them ever bangs their head or ends up in A&E. She says she has no idea of what she should be doing as a mother and whether she is doing the right things for her daughter. Five months down the line, she felt the only person she was getting psychological support from was in fact her divorce solicitor.

The breakdown of her marriage did nothing to help the psychological wellbeing of Mrs A, and the inconclusive examination findings put her in an uncomfortable, uncertain position. Mrs A says Mr A is allowed contact with Child A but she doesn't know whether this is beneficial or more damaging for her daughter and no-one has been able to offer her advice on this issue. Mrs A told me she truly wishes that Mr A's story is true but deep down she is doubtful. The ISVA at the centre had made contact with her, but Mrs A stated she wanted to put her experiences and connection with the centre behind her so that she could "move on."

As a 30-something, professional full time, working mother, she wants to know who to turn to if her child makes another disclosure or starts talking about the incident again. What does she say to her child and how should she react? Should she ignore or acknowledge it and who should she contact if this happens? She wonders if there will be any long term consequences and should she ever tell her daughter about what happened. I couldn't answer those questions for her but clearly the need for a specialist counsellor or psychologist for parents following child sexual abuse is dire. A health visitor sees the family every so often and indeed suggested referral to a psychological support service for Mrs A herself, but was told "I can't do a referral on your behalf because we will get charged."

3. Discussion

The above scenario is not uncommon; many parents coming to the centre find themselves in a similar position and non-offending parents in cases of intra-familial sexual abuse experience significant difficulty as a result.[2,3] The child is not the only victim in these cases.

The psychological implications of rape and sexual assault are extreme but also vary from person to person.[2] In cases involving children it is nearly always the mother who brings them to the centre, often the perpetrator is somebody known to her or the child, most often the biological father, stepfather, uncle, another carer, or sometimes a sibling.[1,4] Not only does the parent have to deal with the fact their child has been sexually abused and the subsequent implications that this can have on behaviour, friendships, school and child care, but they often have to deal with their own personal turmoil, feelings of guilt and self-blame.[2] In addition, they often have to deal with a separation of some sort, be it from their partner, spouse, sibling, parent etc. Social difficulties or problems at work, as well as their own psychological wellbeing are often overlooked.[2,3] This can be because the parent is "fine" and focussed on caring for their child and denies the need for help, but we also need to recognise the parent or carer is a victim too.

Until recently, counselling could be provided at the centre to those wishing to access it. Funding for this was reorganised and complainants are now signposted to other agencies or charities for follow up psychological support instead. The way children and parents access aftercare can be somewhat of a grey area. Some of these organisations are under immense financial pressure and it is well known charities have taken huge hits to their budgets since the beginning of the recession.

Unfortunately finances, waiting lists, organisational or geographical issues are obstacles that prevent or delay victims from receiving the best possible care. Mrs A was told to arrange her own self-referral because the health visitor's department would get the bill. She never made that self-referral. Victims often need to seek help from these agencies or charities themselves, and although the SAFE centre make every effort to signpost and refer onto relevant organisations, it can be difficult to get these organisations or agencies to accept the referrals.

Many parents or carers would not necessarily know who to contact in the future, or neglect the fact they themselves are in need of support as well as the child. They may not wish to make contact with the centre again (like Mrs A), or may not feel confident enough to self-refer to other organisations so it is important to be approachable and open minded when dealing with parents. The feelings Mrs A describes are somewhat part of a normal grief process, but self-blame can also be linked to the theory of secondary victimisation.[2–5]

The Survivor's Trust can offer therapy and specialist counselling sessions, as can various other organisations but these are incredibly location dependant with variable waiting times. Most of these services only take adult victims, not parents or children. Specialist behavioural psychology and counselling services for children who have been sexually assaulted and their parents are unavailable as it is an extremely specialised area. CAMHS (Child and Adolescent Mental Health Services) will not accept these cases due to strict criteria, a lack of specialist expertise or funding. CAMHS would be an ideal organisation to work with parents or carers of children displaying behavioural or psychological problems following abuse due to their vast experience of child psychology. Educational support is scarce and there are extremely limited specific services for dealing with the immediate psychological and behavioural problems faced and how parents/carers should manage them. Teachers are often informed via the school nurse or social services and can help with behavioural issues in school, as long as they are made aware and have the time and skills to do so.

Counselling and psychological therapy for victims has proven benefits, and is recommended by the Crown Prosecution Services (CPS), the Faculty of Forensic and Legal Medicine and the Royal College of Paediatrics and Child Health.[6–8] Working Together to Safeguard Children, guidance produced by the Department of

Education also states the need for psychological support following abuse.[9] Counselling is known to improve the psychological wellbeing of the child long term, to improve confidence and self-esteem, as well as building back trusting relationships.[7] A variety of psychiatric conditions are associated with child sexual abuse; depression, anxiety, personality disorders, suicidality and schizophrenia to name a few; thus the more early support these children have the better to avoid these problems and to also deal with them early should they arise.[2,5,10]

Post-traumatic stress disorder is sometimes seen in children following abuse; counselling and psychotherapy such as cognitive behavioural therapy help minimise the long term impact of this and reduce the risk of secondary victimisation, but the general practitioner is also important in managing this and other mental health issues.[2–5,10]

Immediately following the abuse and before trial is arguably when the child is most vulnerable but when intervention is most needed; the CPS has specific guidance advocating pre-trial therapy and it is a misconception that children should not receive pre-trial therapy.[8] ISVAs can support the child and carers through the court process, go on court visits, and explain the court process to relieve the fears and unfamiliarity surrounding the trial.[1] However, if psychotherapy and counselling are offered at an early and appropriate stage, the child may be in a much better mental state and more prepared for the trial.[6–10] It is important not to rush any therapy close to trial or to commence it too soon after the abuse and each child should have therapy tailored to their specific needs.[7,8] If these issues are dealt with early, the stresses and anxieties about the abuse can be reduced so that the court and evidence process are less traumatic.[7,8]

The collapse of criminal cases where children have become too distressed to give evidence at trial, especially during cross-examination is devastating and arguably avoidable.[7–10] NSPCC research in 2013 found that just 2% of all child witnesses in sexual abuse trials had received appropriate pre-trial therapy, yet over 50% admitted having difficulty sleeping and eating, depression, panic attacks and self-harming prior to the trial and the CPS is ultimately responsible for organising therapy for witnesses.[8,10] However, psychotherapy and counselling will not be appropriate for all children; an individualised approach should be taken to each child.[7–9] Surely we should deal with issues as soon as possible so that the child and their parents/carers are as prepared for giving evidence at trial as possible and prepared to support the child. Additional funding, training and resources should be offered to ensure pre-trial therapy is delivered adequately, thoroughly and at an appropriate time to all children in need of it.

Many of the organisations that offer counselling and psychotherapy refuse to accept children pre-trial because of the myth that it is in some way tampering with evidence or “coaching” the child.[7,8] More established, larger sexual assault counselling services only see adult cases and are unable to accept children or their parents/carers unless they have been abused themselves.[1] Furthermore, if a child has not directly been abused but has witnessed sexual abuse or is displaying worrying, sexualised behaviour or signs of abuse, they are often not eligible for a referral on that alone.[1] It is only once an allegation specifically regarding the child has been made and a police case opened will agencies like the NSPCC then accept a referral.[1]

Although support can be offered by numerous agencies, there isn't always the continuity of care that some vulnerable victims need. A well trained counsellor or social worker who has a good rapport with the victim and their family should be able to provide care for as long as they need. Handover of care or multiple referrals to different agencies, involving different people isn't always in the victim's best interests. This is especially so in children where it can take much longer for them to build a rapport, and the importance of using the same social worker or foster placements where available is underestimated.[1]

Guidelines state trained counsellors with specialist expertise should be available for all victims of sexual assault, be it children or adults.[4–8,10] In our opinion, this should extend to parents or carers of abused children too. Although the ISVAs at the centre have a wealth of experience and much to offer, they are not trained counsellors and do not have formal counselling qualifications.[1] There are pros and cons to having ISVAs not giving counselling; some may wish to separate their experiences in counselling from the more long term ISVA support, whereas some may have difficulty building up a rapport with a new person. The ISVAs at the centre are an invaluable asset but there is room for extension of their role.

3.1. Recommendations

ISVAs could work as part as a multi-agency effort to empower and help victims and their families, whilst remaining independent. Ideally, a more structured, national system should be put in place so that these services are not location dependant and funding protected. These issues are not new to local commissioners, and the passing on of responsibility of commissioning sadly hinders progress.

Schools play an important role in identifying and managing children. Often a senior teacher or the school nurse liaises with the child and parents/carers and schools have a statutory responsibility for safeguarding. Furthermore, the liaison between schools, social services and police are thorough from our experience; sharing information and multi-agency communication is now well recognised.[1] Educational psychologists and CAMHS could be more available or trained to deal with educational and psychosocial issues in schools should they arise and be ready to intervene early.

It is well known multi-agency working is beneficial in all organisations, especially in the NHS. A multidisciplinary approach involving CAMHS, psychologists, counsellors, school nurses, teachers and teaching assistants, health visitors, general practitioners, social workers and parents could be adopted. A tailored, early, multi-agency approach to the care of children and their families could decrease the long term impact of the abuse.

Social services often take charge of case management; case conferences ran by the local authority invite all relevant professionals for a multi-disciplinary conference where the case is discussed. It could be suggested that a wider range of professionals are invited to case conferences, including representatives from the school, counsellors, ISVAs and anyone else involved with the child to ensure a more holistic approach to their care. Most importantly, these discussions need to be communicated thoroughly with all relevant professionals.

In the aftermath of the recent high profile historic sex abuse scandals in the U.K. involving Jimmy Saville et al., surely we should take this opportunity for debate to develop a more comprehensive and thorough system to ensure we look after the psychological wellbeing of all victims properly. Investigating allegations, gaining forensic evidence and criminal prosecutions are all important, but the psychological wellbeing of children, parents and families should also be a priority.

A national, structured system should be commissioned, perhaps centrally to avoid local variation in services. These services could be provided in SARCs in association with ISVAs, but could also be provided in the community if victims do not want to revisit the same place they had their examination. The role of a specialist counsellor who can offer psychological support, educational and behavioural advice, social support as well as supporting and counselling parents/carers should be considered. These could run parallel to the charities already offering some of these services;

some of which could merge to ensure continuity of care. A sexual assault case manager could be established to look after the child and family whilst working alongside other professionals. Furthermore, we should also consider developing and distributing more thorough advice for parents and other professionals, detailing the aftercare available, what will happen next as well as how to manage the child's behavioural and psychological needs.

Ethical approval

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Conflict of interest

I declare there are no conflicting interests of either author.

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